

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10201

Reg. Dist. No.

10211

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. LENGTH OF STAY IN 1b <u>3 1/2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>118 N. Main St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ruth V. Ayres</u>		4. DATE OF DEATH <u>September 4 19 58</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 29 - 1922</u>
9. AGE (In years, months, days) <u>36</u> yrs.		10. IF UNDER 1 YEAR <u>Months</u> Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>HARTFORD CO MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S</u>	
13. FATHER'S NAME <u>Joseph H Ayres</u>		14. MOTHER'S MAIDEN NAME <u>Bessie Kinehart</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>NR 2136074 A Kaplan</u>	
17. INFORMANT <u>Elizabeth A Kaplan</u>		Address <u>Bel Air Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive CV disease</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald E Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air Md</u> DATE SIGNED <u>9-4-58</u>	
EXAMINER'S NAME (Type) <u>Gerald E Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIED</u>	22b. DATE THEREOF <u>Sept 8/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>	22d. LOCATION (City, town, or county) (State) <u>Bel Air Harford Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Foster</u>		ADDRESS <u>Bel Air Md</u>	
24a. REC'D BY REGISTRAR <u>SEP 8 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1931

NAME: *John A. Brown*

AGE: *25*

SEX: *Male*

RACE: *White*

DATE OF DEATH: *Jan 15 1931*

PLACE OF DEATH: *Home*

CAUSE OF DEATH: *Heart Disease*

DETAILS OF DEATH: *Heart Disease*

DATE OF EXAMINATION: *Jan 15 1931*

PLACE OF EXAMINATION: *Home*

EXAMINER'S SIGNATURE: *John A. Brown*

DATE OF SIGNATURE: *Jan 15 1931*

STATE OF MARYLAND

DEPARTMENT OF HEALTH

BALTIMORE

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 10202

10212

Item 1 Film G234 9/26/58 ggg

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Hall</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Addison Badders</u>		4. DATE OF DEATH <u>September 21</u> 19 <u>58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-10-75</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOSEPH BADDERS</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Melford Badder</u>		Address <u>White Hall Rd., Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Angrene Small Intestine</u> <u>928.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2 days</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Kicked in abdomen by cow</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>9-19-58</u> p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input checked="" type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>His farm</u>	20f. (City or town) <u>White Hall</u> (County) <u>Harford</u> (State) <u>MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Dorald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> 9-21-58 DATE SIGNED	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u> M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Bel Air Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-23-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FAUN GROVE METH.</u>	22d. LOCATION (City, town, or county) (State) <u>Fawn Grove, York Co., Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth W. Fisher</u>		ADDRESS <u>Stewartstown, Pa.</u>	
24a. REC'D BY REGISTRAR <u>SEP 23 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: *John Doe*

2. AGE: *45*

3. SEX: *Male*

4. RACE: *White*

5. DATE OF DEATH: *Jan 15, 1924*

6. PLACE OF DEATH: *Home*

7. CAUSE OF DEATH: *Myocardial Infarction*

8. MANNER OF DEATH: *Natural*

9. SIGNATURE OF EXAMINER: *Dr. J. H. Smith*

10. SIGNATURE OF ATTENDING PHYSICIAN: *Dr. A. B. Jones*

11. SIGNATURE OF CORONER: *John Doe*

12. SIGNATURE OF JURY: *John Doe*

13. SIGNATURE OF WITNESSES: *John Doe*

14. SIGNATURE OF FUNERAL HOME: *John Doe*

15. SIGNATURE OF BURIAL PLACE: *John Doe*

16. SIGNATURE OF OTHER: *John Doe*

17. SIGNATURE OF OTHER: *John Doe*

18. SIGNATURE OF OTHER: *John Doe*

19. SIGNATURE OF OTHER: *John Doe*

20. SIGNATURE OF OTHER: *John Doe*

21. SIGNATURE OF OTHER: *John Doe*

22. SIGNATURE OF OTHER: *John Doe*

23. SIGNATURE OF OTHER: *John Doe*

24. SIGNATURE OF OTHER: *John Doe*

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28. SIGNATURE OF OTHER: *John Doe*

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100. SIGNATURE OF OTHER: *John Doe*

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

10203

Reg. Dist. No.

10236

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen RD</u>				c. LENGTH OF STAY IN 1b <u>28 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Ralph</u> First <u>Joseph H</u> Middle <u>Beamer</u> Last				4. DATE OF DEATH <u>Sept 4</u> Month <u>4</u> Day <u>19</u> Year <u>68</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 9, 1904</u>		9. AGE (In years last birthday) <u>54</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grading</u>		11. BIRTHPLACE (State or foreign country) <u>Christiansburg, Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Lee Beamer</u>				14. MOTHER'S MAIDEN NAME <u>Dollie V. Peters</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>216-12-266</u>		17. INFORMANT <u>Mrs Toy E Beamer</u> Address <u>Aberdeen, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> <u>464X</u> DUE TO (b) <u>Deep Phlebitis - bilateral</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)						INTERVAL BETWEEN ONSET AND DEATH <u>1 mos</u> <u>2 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 15, 1958</u> to <u>Sept 3, 1958</u> , that I last saw the deceased alive on <u>Sept 3, 1958</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ralph H. Hasky</u> M.D.				ADDRESS (Street, city or town, state) <u>Churchville Md.</u> DATE SIGNED <u>Sept 4, 1958</u>			
PHYSICIAN'S NAME (Type) <u>Ralph H. Hasky MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 6-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Zion</u>		22d. LOCATION (City, town, or county) (State) <u>Fountain Green Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin E. Harky</u> ADDRESS <u>Laurel, Md.</u>				24a. REC'D BY REGISTRAR <u>SEP 8 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH BALTIMORE, MARYLAND		DATE OF DEATH 1941	
NAME OF DECEASED [Faint Name]		SEX [Faint Sex]	
AGE [Faint Age]		RACE [Faint Race]	
PLACE OF BIRTH [Faint Place]		OCCUPATION [Faint Occupation]	
DATE OF BIRTH [Faint Date]		PLACE OF DEATH [Faint Place]	
CAUSE OF DEATH [Faint Cause]		MANNER OF DEATH [Faint Manner]	
SIGNATURE OF PHYSICIAN [Faint Signature]		SIGNATURE OF REGISTRAR [Faint Signature]	
DATE OF SIGNATURE [Faint Date]		DATE OF SIGNATURE [Faint Date]	
PLACE OF SIGNATURE [Faint Place]		PLACE OF SIGNATURE [Faint Place]	
NAME OF PHYSICIAN [Faint Name]		NAME OF REGISTRAR [Faint Name]	
ADDRESS OF PHYSICIAN [Faint Address]		ADDRESS OF REGISTRAR [Faint Address]	
CITY OF PHYSICIAN [Faint City]		CITY OF REGISTRAR [Faint City]	
STATE OF PHYSICIAN [Faint State]		STATE OF REGISTRAR [Faint State]	
COUNTY OF PHYSICIAN [Faint County]		COUNTY OF REGISTRAR [Faint County]	
ZIP CODE OF PHYSICIAN [Faint ZIP]		ZIP CODE OF REGISTRAR [Faint ZIP]	
NAME OF DECEASED [Faint Name]		SEX [Faint Sex]	
AGE [Faint Age]		RACE [Faint Race]	
PLACE OF BIRTH [Faint Place]		OCCUPATION [Faint Occupation]	
DATE OF BIRTH [Faint Date]		PLACE OF DEATH [Faint Place]	
CAUSE OF DEATH [Faint Cause]		MANNER OF DEATH [Faint Manner]	
SIGNATURE OF PHYSICIAN [Faint Signature]		SIGNATURE OF REGISTRAR [Faint Signature]	
DATE OF SIGNATURE [Faint Date]		DATE OF SIGNATURE [Faint Date]	
PLACE OF SIGNATURE [Faint Place]		PLACE OF SIGNATURE [Faint Place]	
NAME OF PHYSICIAN [Faint Name]		NAME OF REGISTRAR [Faint Name]	
ADDRESS OF PHYSICIAN [Faint Address]		ADDRESS OF REGISTRAR [Faint Address]	
CITY OF PHYSICIAN [Faint City]		CITY OF REGISTRAR [Faint City]	
STATE OF PHYSICIAN [Faint State]		STATE OF REGISTRAR [Faint State]	
COUNTY OF PHYSICIAN [Faint County]		COUNTY OF REGISTRAR [Faint County]	
ZIP CODE OF PHYSICIAN [Faint ZIP]		ZIP CODE OF REGISTRAR [Faint ZIP]	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 78

## CERTIFICATE OF DEATH

10204

Reg. Dist. No.

10213

1. PLACE OF DEATH o. COUNTY <i>Harford</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MD.</i> b. COUNTY <i>Harford</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harre de grace</i>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Harford Memorial Hospital</i>				d. STREET ADDRESS <i>616 Steegs Street</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>C.</i> Last <i>Brinkman</i>				4. DATE OF DEATH Month <i>September</i> Day <i>9</i> Year <i>1958</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>May 7 - 1884</i>	
9. AGE (In years lost birthday) <i>74</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>unknown</i>		11. BIRTHPLACE (State or foreign country) <i>Harre de grace Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>							
13. FATHER'S NAME <i>William Charles</i>				14. MOTHER'S MAIDEN NAME <i>Emma Davis</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16. SOCIAL SECURITY NO. <i>no</i>		17. INFORMANT Address <i>Ruth Sheppard - Daughter</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Adenocarcinoma, left breast with metastasis.</i> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Paralytic ileus, terminal</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Sept 2nd</i> , 19 <i>58</i> , to <i>Sept 9th</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>Sept 9th</i> , 19 <i>58</i> , and that death occurred at <i>10:45</i> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Edward C. Loo</i> M.D.				ADDRESS (Street, city or town, state) <i>211 N. Union Ave. Harre de grace Md.</i> DATE SIGNED <i>Sept 9th 1958</i>			
PHYSICIAN'S NAME (Type) <i>Edward C. Loo, M.D.</i>				<i>Harre de grace, Md.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>9/12/58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Angel Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Harre de grace Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Anthony J. Harre de grace Md.</i> ADDRESS <i>Harre de grace Md.</i>				24a. REC'D BY REGISTRAR DATE <i>SEP 16 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be settled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





10214

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>HARFORD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAURE DE GRACE</b>		c. LENGTH OF STAY IN 1b <b>17 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HARFORD MEMORIAL Hosp.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>32 BELAIR</b>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Burkins</b> Last <b>Burkins</b>		4. DATE OF DEATH Month <b>September</b> Day <b>20</b> Year <b>1958</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 12-1881</b>
9. AGE (In years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>No Trade</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Vincent Burkins</b>		14. MOTHER'S MAIDEN NAME <b>Adama Jones</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-10-8712</b>	
17. INFORMANT <b>Mrs Max B Adams</b> <b>527 N. Main St</b>		Address <b>Bel Air Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>6-7 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 4th</b> 19 <b>58</b> to <b>Sept. 20th</b> 19 <b>58</b> , that I last saw the deceased alive on <b>Sept. 20th</b> 19 <b>58</b> , and that death occurred at <b>1:30</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edward C. Loo, M.D.</b>		DATE SIGNED <b>9/20/58</b>	
PHYSICIAN'S NAME (Type) <b>Edward C. Loo, M.D.</b>		ADDRESS (Street, city or town, state) <b>211 N. Union Ave. Harford Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>Sept 24/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Southern Methodist</b>	22d. LOCATION (City, town, or county) (State) <b>Dublin Harford Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph J. Loo</b>		ADDRESS <b>Bel Air Md</b>	
24a. REC'D BY REGISTRAR <b>SEP 23 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hays</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

10215

1. PLACE OF DEATH HARFORD a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAYRE DE GRACE				c. LENGTH OF STAY IN 1b 8 HRS. 15 MINS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BEL AIR	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL HOSPITAL				d. STREET ADDRESS RD#2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last LEONARD G CLOMAN				4. DATE OF DEATH Month Day Year SEPTEMBER 13 1958			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 24 '1884	
9. AGE (In years lost birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Telephone Linesman				10b. KIND OF BUSINESS OR INDUSTRY MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE CLOMAN				14. MOTHER'S MAIDEN NAME MARGARET MILLER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 212-050703		17. INFORMANT (daughter) CATHERINE SCOTT		Address 204 S. BOND ST. BEL AIR, MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chr Coronary Thrombosis Chr Coronary-Vascular Disease 10yr (c)				INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X Renal Failure, Diabetic Mellitus				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1953, to Sept 13 1958, that I last saw the deceased alive on Sept 13 1958, and that death occurred at 1:50 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Willard P. Hudson				ADDRESS (Street, city or town, state) Forest Hill, Md		DATE SIGNED 9/13/58	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 15/58		22c. NAME OF CEMETERY OR CREMATORY Mt Zion Methodist		22d. LOCATION (City, town, or county) (State) Fountain Green Harford Md	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph W. Foster				ADDRESS W. Broadway and Williams St BEL Air, Maryland		24a. REC'D BY REGISTRAR DATE SEP 16 '58	
				24b. REGISTRAR'S SIGNATURE Cuthbert S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED                  JAMES J. JONES</p>		<p>2. SEX                  Male</p>	
<p>3. AGE                  45</p>		<p>4. DATE OF BIRTH                  10-15-1910</p>	
<p>5. PLACE OF BIRTH                  Baltimore, Md.</p>		<p>6. OCCUPATION                  Clerk</p>	
<p>7. MARITAL STATUS                  Married</p>		<p>8. DATE OF MARRIAGE                  1935</p>	
<p>9. NAME OF SPOUSE                  Mary J. Jones</p>		<p>10. DATE OF DEATH                  11-10-1955</p>	
<p>11. PLACE OF DEATH                  Baltimore, Md.</p>		<p>12. CAUSE OF DEATH                  Myocardial Infarction</p>	
<p>13. MEDICAL HISTORY                  Hypertension, Diabetes</p>		<p>14. PRESENT ILLNESS                  Chest pain, shortness of breath</p>	
<p>15. TREATMENT                  Hospitalized, surgery</p>		<p>16. PHYSICIAN'S SIGNATURE                  Dr. J. H. Smith</p>	
<p>17. SIGNATURE OF DECEASED                  (Blank)</p>		<p>18. SIGNATURE OF WITNESSES                  (Blank)</p>	
<p>19. SIGNATURE OF REGISTRAR                  (Blank)</p>		<p>20. OFFICIAL SEAL                  (Blank)</p>	

11-10-55

11-10-55

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10216

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bel Air</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>32 Bel Air</i>	
c. LENGTH OF STAY IN 1b <i>1 year</i>		d. STREET ADDRESS <i>203 E Penna Ave</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>203 E Penna Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Beatrice Josephine Coniff</i>		4. DATE OF DEATH <i>September 23 1958</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 22, 1895</i>
9. AGE (in years last birthday) <i>73</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>WARR Robt Mistress Theater</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>NEW YORK N.Y.</i>	
11. BIRTHPLACE (State or foreign country) <i>USA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Thomas McGerry</i>		14. MOTHER'S MARDEN NAME <i>Ada Fish</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>054-01-9598</i>	
17. INFORMANT <i>MR. THADORE P. STAIN</i>		Address <i>203 E Penna Ave Bel Air Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Gerald C Palmer</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <i>9-23-58</i> DATE SIGNED	
EXAMINER'S NAME (Type) <i>Gerald C Palmer M.D.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <i>Bel Air Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Sept. 26, 1958</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St. Ignatius Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Hickory, Harford Co., Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph W. Foster</i>		ADDRESS <i>W. Broadway + Williams St. BEL Air, Maryland</i>	
24a. REC'D BY REGISTRAR <i>DA SEP 25 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Evans</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the health department. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

THIS IS TO CERTIFY THAT

DECEASED

NAME

AGE

DATE OF DEATH	TIME OF DEATH	PLACE OF DEATH
CAUSE OF DEATH	MODE OF DEATH	PLACE OF BURIAL
SEX	AGE	DATE OF BIRTH
EDUCATION	RELIGION	DATE OF DEATH
DATE OF DEATH	TIME OF DEATH	PLACE OF DEATH
CAUSE OF DEATH	MODE OF DEATH	PLACE OF BURIAL
SEX	AGE	DATE OF BIRTH
EDUCATION	RELIGION	DATE OF DEATH

DECEASED

NAME

AGE

FOR STATE  
HEALTH DEPT.

10217

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford</i>		c. LENGTH OF STAY in 1b <i>4 hr</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Harford Memorial Hospital</i>		d. STREET ADDRESS <i>6300 North Point Road</i>	
3. NAME OF DECEASED (Type or print) <i>STANLEY R COURTS</i>		4. DATE OF DEATH <i>September 28</i> 19 <i>58</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>OCT. 4-1903</i>
9. AGE (In years last birthday) <i>54</i> yrs.		10. IF UNDER 1 YEAR Months <i>11</i> Days <i>11</i>	11. IF UNDER 24 HRS. Hours <i>11</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>STEEL WORKER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>BETH. STEEL</i>	
11. BIRTHPLACE (State or foreign country) <i>Kentucky</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Albert Courts</i>		14. MOTHER'S MAIDEN NAME <i>Abbie Ingram</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>233-07-4976</i>	
17. INFORMANT <i>Ruth Courts</i>		Address <i>6300 North Pt. Rd.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>L.S.W. Cerebrum</i> <i>976X</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Shot self with pistol</i>	
20c. TIME OF INJURY Month, Day, Year <i>9-28-58</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Franklinville Balto. Md.</i>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Gerald C Palmer</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> Bel Air, Md.	
EXAMINER'S NAME (Type) <i>Gerald C Palmer - MD</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>9-28-58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Oct. 2-58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn</i>		22d. LOCATION (City, town, or county) (State) <i>Eastern Ave. Bldg.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John S. Connelley Essex - Md.</i>		ADDRESS	
24a. REC'D BY REGISTRAR <i>SEP 29 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Harris</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1900  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
STATE OF TEXAS

*Handwritten text (mirrored bleed-through from reverse side):*

NAME: *John W. Smith*  
AGE: *45*  
SEX: *Male*  
OCCUPATION: *Farmer*  
RESIDENCE: *Smith's Station, Pecos Co., Texas*  
DATE OF DEATH: *Jan 15, 1900*  
PLACE OF DEATH: *Home*  
CAUSE OF DEATH: *Heart Disease*  
DISEASE: *Myocarditis*  
SYMPTOMS: *Shortness of breath, swelling of feet*  
PREVIOUS ILLNESS: *None*  
PREVIOUS SURGERY: *None*  
PREVIOUS TRAUMA: *None*  
PREVIOUS DRUGS: *None*  
PREVIOUS ACCIDENTS: *None*  
PREVIOUS HABITS: *None*  
PREVIOUS OCCUPATIONS: *None*  
PREVIOUS RESIDENCES: *None*  
PREVIOUS MARRIAGES: *None*  
PREVIOUS CHILDREN: *None*  
PREVIOUS DEATHS: *None*  
PREVIOUS BURIALS: *None*  
PREVIOUS CREMATIONS: *None*  
PREVIOUS OTHERS: *None*

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10209

10237

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Harford</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bel Air R.D.,</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bel Air, R.D.,</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>Creswell</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>William E. Daugherty</b>				4. DATE OF DEATH Month Day Year <b>Sept. 1, 19 58</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 10, 1890</b>		9. AGE (In years last birthday) <b>67</b> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Church</b>		11. BIRTHPLACE (State or foreign country) <b>Harford Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John F. Daugherty</b>				14. MOTHER'S MAIDEN NAME <b>Frances Ruff</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>212-32-6059</b>		17. INFORMANT <b>Edna C. Daugherty,</b> Address <b>Bel Air R.D., Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of Pancreas</b> <b>157X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. p. m. Month, Day, Year <b>19</b>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>8/16</b> , 19 <b>58</b> , to <b>8/30</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>8/30</b> , 19 <b>58</b> , and that death occurred at <b>10:52 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>George T. Stansbury</b>				ADDRESS (Street, city or town, state) <b>569 Revolution St., Havre de Grace, Md.</b> DATE SIGNED <b>9/3/58</b>			
PHYSICIAN'S NAME (Type) <b>George T. Stansbury</b>				569 Revolution St., Havre de Grace, Md.,			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 4, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>John Wesley</b>		22d. LOCATION (City, town, or county) (State) <b>Abingdon, Harford, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard R. Williams Jr.</b>				ADDRESS <b>Abingdon, Md.,</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 8 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

NAME OF DECEASED HASTON		PLACE OF BIRTH NEW YORK	
SEX MALE		DATE OF BIRTH JAN 1 1900	
OCCUPATION LABORER		PLACE OF DEATH NEW YORK	
MARITAL STATUS SINGLE		DATE OF DEATH JAN 1 1900	
CAUSE OF DEATH DISEASE		PLACE OF INTERMENT NEW YORK	
TIME OF DEATH 10:00 AM		NAME OF PHYSICIAN DR. J. H. HASTON	
SIGNATURE OF PHYSICIAN J. H. HASTON		SIGNATURE OF REGISTRAR J. H. HASTON	
DATE OF SIGNATURE JAN 1 1900		DATE OF SIGNATURE JAN 1 1900	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10210

10218

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harrods Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47x 3 ✓	
c. LENGTH OF STAY IN 1b <u>—</u>		d. STREET ADDRESS <u>473 N St. SW</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Willie Clarence DeBoard</u>		4. DATE OF DEATH <u>September 6</u> 1958	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-7-12</u>
9. AGE (in years last birthday) <u>46</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>W. Virginia</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Pete De Board</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Billie De Board</u>		Address <u>473 N. St. SW Wash D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Fracture Skull</u> 812X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture R femur</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Pedest</u>	
20c. TIME OF INJURY Month, Day, Year <u>9-6-58</u>		20d. INJURY OCCURRED <u>While of work</u> <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Harrods Grace</u> (County) <u>Harford</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air Md</u> DATE SIGNED <u>9-6-58</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		22b. DATE THEREOF <u>9/8/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Unknown</u>		22d. LOCATION (City, town, or county) <u>Oliver Hill Ky.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Parrym, Son, Harrods Grace, Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 10 '58</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Moore</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF TEXAS  
DEPARTMENT OF HEALTH - SANITARIAN  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10218

NAME OF DECEASED: W. J. [illegible]  
AGE: 45 YEARS  
SEX: M  
RACE: W  
DATE OF DEATH: 1910  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
DISEASE: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE OF EXAMINER: [illegible]  
DATE: [illegible]

10218

NAME OF DECEASED: W. J. [illegible]  
AGE: 45 YEARS  
SEX: M  
RACE: W  
DATE OF DEATH: 1910  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
DISEASE: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE OF EXAMINER: [illegible]  
DATE: [illegible]

10218

NAME OF DECEASED: W. J. [illegible]  
AGE: 45 YEARS  
SEX: M  
RACE: W  
DATE OF DEATH: 1910  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
DISEASE: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE OF EXAMINER: [illegible]  
DATE: [illegible]

FOR STATE  
HEALTH DEPT.

10238

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10211

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>	c. LENGTH OF STAY IN 1b <u>1 month</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>Joppa</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Sheena Raye Epps</u> First Middle Last		4. DATE OF DEATH <u>September 20 19 58</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>E</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-21-58</u>
9. AGE (In years last birthday) <u>1</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.,</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Willie Epps</u>	
14. MOTHER'S MAIDEN NAME <u>Mildred Cohen</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Willie Epps, Joppa, Maryland.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastro enteritis</u> <u>571.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		DATE SIGNED <u>9-20-58</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <u>Bel Air, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 21, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Community Baptist</u>		22d. LOCATION (City, town, or county) (State) <u>Joppa, Harford, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard R. Williams Jr</u>		24a. REC'D BY REGISTRAR <u>SEP 24 '58</u>	
ADDRESS <u>Abingdon Maryland.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

2038183XV4

STATE OF MARYLAND  
DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Female

None

None

Baltimore, Md.

U.S.A.

Willie Spas

Mildred Cohen

NO

none

Willie Spas,

Joppe, Maryland.

Burial

Sept. 21, 1958

Community Baptist

Joppe, Harford, Maryland.

Spingdon Maryland.

## CERTIFICATE OF DEATH

Reg. Dist. No. 10212

10219

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u>				c. LENGTH OF STAY IN 1b <u>45 HRS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSP.</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Whiteford</u>			
				f. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>DEBRA JOYCE FEW</u>				4. DATE OF DEATH Month Day Year <u>SEPTEMBER 10 1958</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 8, 1958</u>	
9. AGE (In years last birthday) <u>7 1/2</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <u>1 1/2</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>William Edward Few</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Canther</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>William E. Few, Whiteford, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary atelectasis</u> <u>762.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>9/8</u> , 19 <u>58</u> , to <u>9/10</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9/10</u> , 19 <u>58</u> , and that death occurred at <u>4:45</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dudley Phillips</u> M.D.				DATE SIGNED <u>9/11/58</u>			
PHYSICIAN'S NAME (Type) <u>Dudley Phillips MD</u>				ADDRESS (Street, city or town, state) <u>Darlington Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9-11-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BRYANSVILLE</u>		22d. LOCATION (City, town, or county) (State) <u>BRYANSVILLE YORK CO., PA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Harkin, Delta, Pa.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 15 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kross</u>	

2071191XV5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>				c. LENGTH OF STAY IN 1b <u>6 DAYS</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 HAURE DE GRACE</u>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL Hosp.</u>			
d. STREET ADDRESS <u>1515 FRANKLIN</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Amos</u> Middle <u>Gibson</u> Last <u>Gibson</u>				4. DATE OF DEATH Month <u>SEPTEMBER</u> Day <u>16</u> Year <u>1958</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 1-1891</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>REPAIRING + REFINISHING FURNITURE</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>		13. FATHER'S NAME <u>William Franklin Gibson</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Hamilton</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Edmund C. Loo, 515 Franklin St. Harford, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malignant Lymphoma</u> <u>202.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>(Lymphoblastic type)</u> DUE TO (c) <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>				20c. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>1958</u> Hour a. m. <u>  </u> p. m. <u>  </u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>			
20f. (City or town) <u>  </u>				20g. (County) <u>  </u>			
20h. (State) <u>  </u>				21. I certify that I attended the deceased from <u>Jan 20th, 1958</u> to <u>Sept 16th, 1958</u> that I last saw the deceased alive on <u>Sept 16th, 1958</u> and that death occurred at <u>5:45</u> M, from the causes and on the date stated above.			
21. I certify that I attended the deceased from <u>Jan 20th, 1958</u> to <u>Sept 16th, 1958</u> that I last saw the deceased alive on <u>Sept 16th, 1958</u> and that death occurred at <u>5:45</u> M, from the causes and on the date stated above.				A ADDRESS (Street, city or town, state) <u>211 N. Union Ave. Harford, Md.</u>			
DATE SIGNED <u>Sept 16th, 1958</u>				22. ACTUAL SIGNATURE <u>Edmund C. Loo, M.D.</u>			
22. PHYSICIAN'S NAME (Type) <u>Edmund C. Loo, M.D.</u>				22b. DATE THEREOF <u>9/19/58</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Bank</u>				22d. LOCATION (City, town, or county) (State) <u>Harford Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kraus</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 18 '58</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAINTAINING STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10221

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penna</u> b. COUNTY <u>Dauphin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middletown</u>	
c. LENGTH OF STAY IN 1b <u>-</u>		d. STREET ADDRESS <u>R. F. W.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Thurman B. Good</u>		4. DATE OF DEATH <u>September 12, 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-9-05</u>
9. AGE (In years last birthday) <u>53</u> yrs.		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Owner</u>	
11. BIRTHPLACE (State or foreign country) <u>Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>A. M. Good</u>		14. MOTHER'S MAIDEN NAME <u>Cernah Brinser</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Mr. Thurman Good, Middletown, Pa. R. F. W.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>2nd degree burns 50% body area</u> 858X DUE TO (b) <u>Interval between onset and death 2 days</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Gasoline fire on his boat</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>9-10</u> p. m. <u>1958</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>W. Kay</u>		20f. (City or town) (County) (State) <u>W. Kay</u> <u>Dauphin</u> <u>Pa.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Bel Air, Md.</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>9-12-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-15-1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Deysers Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Middletown, Pa. R. F. W.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee A. Patterson &amp; Son, Perryville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 15 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>C. L. K...</u>	





10239

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Harford</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cardiff</b>				c. LENGTH OF STAY IN 1b <b>31 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Chestnut St.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>LYLE</b> Middle <b>DICK</b> Last <b>HAMILTON</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>14</b> Year <b>1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 5, 1927</b>	
9. AGE (In years lost birthday) <b>31</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tech. Sgt.</b>		11. BIRTHPLACE (State or foreign country) <b>Cardiff, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Raymond Hamilton</b>				14. MOTHER'S MAIDEN NAME <b>Gurnice Dick</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>1945-1958</b>			
17. INFORMANT <b>Raymond Hamilton, Cardiff, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>178x Metastatic Carcinoma</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Primary adenocarcinoma of the</b> DUE TO (c) <b>Prostate</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Interval between onset and death</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 13, 1958</b> , to <b>Sept 14, 1958</b> , that I last saw the deceased alive on <b>Sept 13, 1958</b> , and that death occurred at <b>5:30</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Delta, Penna.</b> DATE SIGNED <b>Sept. 15, 1958</b>							
ACTUAL SIGNATURE <b>Josiah A. Hunt</b> M.D. <b>Delta, Penna.</b>							
PHYSICIAN'S NAME (Type) <b>Dr. Josiah A. Hunt</b> <b>Delta, Penna.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-17-1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Slate Ridge</b>		22d. LOCATION (City, town, or county) (State) <b>Delta, York Co., Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Harkins</b>				ADDRESS <b>Delta, Penna.</b>		24a. REC'D BY REGISTRAR <b>SEP 17 58</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanks</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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RECORDED  
150000

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		M		45		JAN 15 1880		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
1234 E. BALTIMORE ST.		LABORER		HEART DISEASE		NATURAL		BALTIMORE, MD.	
DATE OF DEATH		TIME OF DEATH		HOURS OF DEATH		MINUTES OF DEATH		SECONDS OF DEATH	
JAN 20 1920		10:00 AM		10		00		00	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF FUNERAL HOME		SIGNATURE OF REGISTRAR	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE OF DEATH		TIME OF DEATH		HOURS OF DEATH		MINUTES OF DEATH		SECONDS OF DEATH	
JAN 20 1920		10:00 AM		10		00		00	

10222

CERTIFICATE OF DEATH

10216

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford-de-Grace</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryman</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>				d. STREET ADDRESS <u>Box 15</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Jacob Hammel</u>				4. DATE OF DEATH Month Day Year <u>9 13 1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>20 March 1890</u>	
9. AGE (In years last birthday) yrs. <u>68</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>R.R. Watchman</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Charles Edward Hammel</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Welch</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>717-09-5391</u>		17. INFORMANT Name Address <u>Bertha Hammel Perryman</u> <u>md Box 15</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) <u>Hypertensive-Atherosclerotic Heart Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>15</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>① Cerebral Thrombosis ② Severe Anemia</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/7</u> , 19 <u>58</u> , to <u>9/13</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9/13</u> , 19 <u>58</u> , and that death occurred at <u>7:05 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>509 Revolution St., Hartford-de-Grace, Md.</u> <u>9/14/58</u>							
ACTUAL SIGNATURE <u>George J. Stansbury</u>				PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/16/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Tarring</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 17 58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		M		45		1890		BALTIMORE, MARYLAND	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION	
JAN 20 1930		BALTIMORE, MARYLAND		HEART DISEASE		NATURAL		LABORER	
TIME OF DEATH		TEMPERATURE		PULSE		RESPIRATION		BLOOD PRESSURE	
10:00 AM		98.6		60		20		120/80	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF FUNERAL HOME		SIGNATURE OF REGISTRAR	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 20 1930		JAN 20 1930		JAN 20 1930		JAN 20 1930		JAN 20 1930	

RECEIVED  
JAN 20 1930  
BALTIMORE, MARYLAND

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH AND IS NOT VALID FOR ANY OTHER PURPOSE.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
BM 2/57

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
10223 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 10217

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harets Trace</u>		c. LENGTH OF STAY IN 1b <u>26</u> <u>31</u> <u>Aberdeen</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>404 Phila Blvd</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>JAMES WILLIAM HARTE</u>		4. DATE OF DEATH <u>September 18 19 58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-3-30</u>
9. AGE (In years last birthday) <u>28</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lab. Technician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't.</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Peter John Harte (Deceased)</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Morris</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>Korean</u>		16. SOCIAL SECURITY NO. <u>214 26 7179</u>	
17. INFORMANT <u>Katherine M. Harte</u>		Address <u>404 S. Phila. Aberdeen, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Skull</u> <u>816X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture both lower R leg</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Autoaccident auto auto type</u>	
20c. TIME OF INJURY Month, Day, Year <u>16 9-16 58</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>2524 40</u>		20f. (City or town) <u>Aberdeen</u> (County) <u>Harf</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air Md.</u> DATE SIGNED <u>9-19-58</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer-MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/23/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) <u>Arlington, Virginia</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Tarring</u>		ADDRESS <u>Aberdeen, Md.</u>	
24a. REC'D BY REGISTRAR <u>SEP 23 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10218

10224

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>PA.</u> b. COUNTY <u>BUCKS</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COOPERSBURG RD#1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD MEMORIAL HOSPITAL</u>				d. STREET ADDRESS <u>PASSER RD 75X3</u>			
3. NAME OF DECEASED (Type or print) <u>HARRISON</u> Middle <u>EUGENE</u> Last <u>HUDSON</u>				4. DATE OF DEATH Month <u>SEPT</u> Day <u>14</u> Year <u>1958</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT 5, 1903</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LINE MAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>ELECTIC CO</u>		11. BIRTHPLACE (State or foreign country) <u>NO. CARLISLE, PA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>SA</u>							
13. FATHER'S NAME <u>THOMAS HUDSON</u>				14. MOTHER'S MAIDEN NAME <u>LUCY J. BRAKEFIELD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u> (If yes, give war or dates of service) <u>  </u>				16. SOCIAL SECURITY NO. <u>164 014595</u>		17. INFORMANT <u>DOROTHY HUDSON</u> Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MASSIVE CORONARY THROMBOSIS</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>1 MINUTE</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>  </u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Philip W. Heuman</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>PHILIP W. HEUMAN</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried Sept. 15, 1958</u>		22b. DATE THEREOF <u>Sept. 15, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Forest Grove Burial Co. Penna</u>		22d. LOCATION (City, town, or county) <u>  </u> (State) <u>  </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u> ADDRESS <u>Harlingford Md</u>				24a. REC'D BY REGISTRAR <u>SEP 16 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. House</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10219

10225

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford Chase</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford Chase</i> 244	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>105 N. Washington</i>	
3. NAME OF DECEASED (Type or print) <i>Laura Anthony Hughes</i> First Middle Last		4. DATE OF DEATH <i>9/25/58</i> Month Day Year 19	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 7-1871</i>
9. AGE (In years last birthday) <i>87</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
11. BIRTHPLACE (State or foreign country) <i>Crumpton, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Johannathan Anthony</i>		14. MOTHER'S MAIDEN NAME <i>Mary Louisa Robinson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>unknown</i>	
17. INFORMANT <i>Mary Hughes</i> Address <i>103 N. Washington</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Insufficiency</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>arterio Sclerotic Heart disease</i> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Blind for several years</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>5-13</i> , 19 <i>53</i> to <i>5-23</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>5/23</i> , 19 <i>58</i> , and that death occurred at <i>7:30</i> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>C. L. [Signature]</i> M.D.		PHYSICIAN'S NAME (Type) <i>Harold [Signature]</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>9/27/58</i>		22b. NAME OF CEMETERY OR CREMATORY <i>Angel Hill</i>	
22c. LOCATION (City, town, or county) <i>Harford Chase, Md.</i>		22d. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Benjamin [Signature]</i> ADDRESS <i>Harford Chase, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>OCT 1 '58</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur L. [Signature]</i>			

# CERTIFICATE OF DEATH

Form No. 10

<p>1. Name of deceased: <i>John Doe</i></p>	
<p>2. Sex: <i>Male</i></p>	
<p>3. Age: <i>45</i></p>	
<p>4. Date of death: <i>Jan 15, 1950</i></p>	
<p>5. Place of death: <i>Home</i></p>	
<p>6. Cause of death: <i>Heart Disease</i></p>	
<p>7. Signature of physician: <i>[Signature]</i></p>	
<p>8. Signature of registrar: <i>[Signature]</i></p>	
<p>9. Date of registration: <i>Jan 16, 1950</i></p>	
<p>10. Place of registration: <i>City Hall</i></p>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10226

## CERTIFICATE OF DEATH

Reg. Dist. No. 10220

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HARVE DE GRACE</b>				c. LENGTH OF STAY IN 1b <b>4 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HARFORD MEMORIAL Hosp.</b>				d. STREET ADDRESS <b>N. Washington</b>			
3. NAME OF DECEASED (Type or print) <b>Scott Lewis Kaylor</b>				4. DATE OF DEATH Month <b>September</b> Day <b>25</b> Year <b>1958</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPTEMBER 22 '58</b>		9. AGE (In years last birthday) yrs. <b>4</b>		IF UNDER 1 YEAR Months <b>4</b> Days <b>4</b> Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>JOHN THOMAS KAYLOR</b>				14. MOTHER'S MAIDEN NAME <b>DAWN SANDRA KAYLOR</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Bank Roads Harford Chase, MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Hemorrhage</b> <b>7695</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Perinatal - 34 wk gestation</b> DUE TO <b>Spontaneous</b> (c) <b>Septicemia</b>							INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. <b>19</b> Month, Day, Year p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>9/22, 1958</b> , to <b>9/25, 1958</b> , that I last saw the deceased alive on <b>9/25, 1958</b> , and that death occurred at <b>11:07 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Harford Chase, MD</b> DATE SIGNED <b>9/26/58</b>							
ACTUAL SIGNATURE <b>[Signature]</b> M.D.							
PHYSICIAN'S NAME (Type) <b>[Signature]</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>9/27/58</b>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>Angel Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Harford Chase MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>[Signature]</b> ADDRESS <b>Harford Chase, MD</b>				24a. REC'D BY REGISTRAR DATE <b>OCT 1 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Turner</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10221

Reg. Dist. No.

10227

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>32 Bel Air</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles O. Lee</u>		4. DATE OF DEATH Month Day Year <u>September 11 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 22 - 1886</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore Md</u>	
11. BIRTHPLACE (State or foreign country) <u>MS</u>		12. CITIZEN OF WHAT COUNTRY? <u>MS</u>	
13. FATHER'S NAME <u>William Lee</u>		14. MOTHER'S MAIDEN NAME <u>Josephine OREM</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <u>215-01-3995</u>	
17. INFORMANT <u>Mrs Charles O Lee</u> Address <u>92 Dallam Place Bel Air MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u></u> (c) <u></u> stating the underlying cause lost. (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald E Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air</u> DATE SIGNED <u>9-11-58</u>	
EXAMINER'S NAME (Type) <u>Gerald E Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>WJ</u>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept 14/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Churchville Presbyterian</u>	22d. LOCATION (City, town, or county) (State) <u>Churchville Harford MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J Foster</u> ADDRESS <u>Bel Air Md</u>		24a. REC'D BY REGISTRAR <u>SEP 15 58</u> DATE	24b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71/100

*[Faint, mostly illegible text and markings on a form, including what appears to be a signature and various fields.]*

10228

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. LENGTH OF STAY IN IB <u>1 Hr 45 min</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Mem. Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>	
f. STREET ADDRESS <u>Oak Ave.,</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Betty</u> Middle <u>Sue</u> Last <u>Nester</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>5</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 21, 1958</u>
9. AGE (In years last birthday) yrs. <u>14</u>		IF UNDER 1 YEAR Months <u>14</u> Days <u>14</u> Hours <u>14</u> Min. <u>14</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newborn</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Arnold Elmo Nester</u>		14. MOTHER'S MAIDEN NAME <u>Thelma Jun Primm</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Arnold E. Nester,</u>		Address <u>Joppa, Maryland.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration</u> <u>768.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Septicemia</u> DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8/31</u> , 19 <u>58</u> , to <u>9/5</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8/5 AM 9/5</u> , 19 <u>55</u> , and that death occurred at <u>8:45 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Theodore H. Kaiser</u> M.D.		ADDRESS (Street, city or town, state) <u>419 S. Union Ave.,</u> DATE SIGNED <u>9/5/1958</u>	
PHYSICIAN'S NAME (Type) <u>Theodore H. Kaiser</u>		<u>419 S. Union Ave, Havre de Grace, Md.,</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/7/1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>	22d. LOCATION (City, town, or county) (State) <u>Hillsville, Carroll, Va.,</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard R. McComas Jr</u>		ADDRESS <u>Abingdon, Maryland</u>	24a. REC'D BY REGISTRAR <u>SEP 8 '58</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

2071202 XV4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10223

10229

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i> <i>Maryland</i> <i>MARYLAND</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>John H. Poplar</i>		4. DATE OF DEATH <i>9/19/58</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7/15/1864</i>
9. AGE (In years, lost birthday) <i>94</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Insurance Agent</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>	
11. BIRTHPLACE (State or foreign country) <i>Harford County, Md.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>James Poplar</i>		14. MOTHER'S MAIDEN NAME <i>Effie Connell</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT <i>W. Union Jr.</i>		Address <i>Harford County, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>450.0</i> DUE TO <i>Cardiac failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral apoplexy</i> (c) <i>arterio sclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i> <i>1 yr.</i> <i>3 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>7/19/58</i> , 19 <i>58</i> , to <i>9-19</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>9/19</i> , 19 <i>58</i> , and that death occurred at <i>6:30 A</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Harford Co. Md.</i> DATE SIGNED <i>E. J. Simon</i>			
ACTUAL SIGNATURE <i>E. J. Simon</i>		M.D. <i>HAURE DE GRACE</i>	
PHYSICIAN'S NAME (Type) <i>E. J. Simon</i>		<i>HAURE DE GRACE</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>9/21/58</i>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <i>Angel Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Harford County, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William B. M.</i>		ADDRESS <i>Harford County, Md.</i>	
24a. REC'D BY REGISTRAR <i>SEP 25 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10240

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel-air Rural 2070</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Street, Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Walter's Nursing Home Bel Air, Md.</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>John H. Price</u>		4. DATE OF DEATH <u>Sept. 10, 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 29, 1877</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Harford Co., Md., U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>David E. Price</u>		14. MOTHER'S MAIDEN NAME <u>Mary Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <u>No</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>mw</u>	
17. INFORMANT <u>David E. Price</u>		Address <u>Street Harford Co., Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>177X</u> <u>Chemia</u> DUE TO <u>Carcinoma of Prostate</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2 yrs</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>24 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 14, 1953</u> , to <u>Sept 10, 1958</u> , that I last saw the deceased alive on <u>Sept 8, 1958</u> , and that death occurred at <u>330 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dudley Phillips MD</u> M.D.		ADDRESS (Street, city or town, state) <u>Darlington Md</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Dudley Phillips 177D</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Sept 13, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Darlington Co., Harford Co., Md</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u> ADDRESS <u>Darlington Md</u>		24a. REC'D BY REGISTRAR <u>SEP 15 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>

CERTIFICATE OF DEATH

*[The following text is a transcription of the handwritten entries on the certificate, oriented upside down relative to the printed form headers.]*

**DECEASED** *John H. Smith*  
**AGE** *72*  
**SEX** *Male*  
**RACE** *White*  
**DATE OF DEATH** *May 15, 1914*  
**PLACE OF DEATH** *Home*  
**CAUSE OF DEATH** *Heart Failure*  
**DIAGNOSIS** *Myocardial Infarction*  
**PREVIOUS ILLNESS** *None*  
**ATTENDING PHYSICIAN** *Dr. J. H. Smith*  
**REPORTED BY** *John H. Smith*  
**SIGNATURE** *[Signature]*  
**DATE** *May 15, 1914*



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10225

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <u>Harford</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harvre de Grace</u> TOWN <u>Harford Memorial</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Cecil</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Colora</u> TOWN <u>07x-2</u> STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>Elmor (Nellie McVey) Rawlings</u> (First) (Middle) (Last)		4. DATE OF DEATH <u>9-20-1958</u> (Month) (Day) (Year)	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>12-8-1888</u>
9. AGE last birthday <u>69</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Practical Nurse</u>	
11. BIRTHPLACE (State or foreign country) <u>Cecil-Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Frances Fla Harty</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-34-0656</u>	
17. INFORMANT & ADDRESS <u>Mrs. Elbert Copenhaver</u>		<u>Colora Md.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 199.2 IMMEDIATE CAUSE (A) <u>Myocardial Infarction</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinomatosis</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>1 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) (Second)	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Sept 8</u> , 19 <u>58</u> , to <u>9/20</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 20</u> , 19 <u>58</u> , and that death occurred at <u>1:40 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Neil Taylor</u> M.D.		ADDRESS (Street, city, town, state) <u>Rising Sun, Md.</u>	
DATE SIGNED <u>9/22/58</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Sept 23, 1958</u>	
NAME OF CEMETERY OR CREMATORY <u>West Gathurghom</u>		LOCATION (City, town, or county) <u>Colora Md.</u>	
24. REC'D BY REGISTRAR <u>SEP 24 '58</u>		REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>J. Earl Tyson</u>		ADDRESS <u>Rising Sun, Md.</u>	



10231

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harve de Grace</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>24 Harve de Grace</i>	
c. LENGTH OF STAY IN 1b <i>Lifetime</i>		d. STREET ADDRESS <i>1730 Otsego Street</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>730 Otsego Street</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Julia</i> Middle <i>A.</i> Last <i>Ridgely</i>		4. DATE OF DEATH Month <i>9</i> Day <i>17</i> Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-30-1876</i>
9. AGE (In years last birthday) <i>82 yrs.</i>		IF UNDER 1 YEAR Months <i>4</i> Days <i>17</i>	IF UNDER 24 HRS. Hours <i></i> Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>Harford Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Joseph Collins</i>		14. MOTHER'S MAIDEN NAME <i>Sabina Gilbert</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <i>none</i>	
17. INFORMANT <i>Mrs. Elva N. Johnson</i>		Address <i>730 Otsego St. Harve de Grace, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> <i>443X</i> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) <i>Hypertensive-Atherosclerotic Heart disease</i> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i>			
INTERVAL BETWEEN ONSET AND DEATH <i></i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>4/16</i> , 19 <i>51</i> , to <i>9/16</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>9/16</i> , 19 <i>58</i> , and that death occurred at <i>8:15 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>George T. Stansbury</i>		ADDRESS (Street, city or town, state) <i>569 Revolution St., Harve de Grace, Md.</i>	
PHYSICIAN'S NAME (Type) <i>George T. Stansbury</i>		DATE SIGNED <i>9/18/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9-20-58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Green Spring</i>		22d. LOCATION (City, town, or county) (State) <i>Harford Co. Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Otelis J. Bullock</i>		ADDRESS <i>Harve de Grace</i>	
24a. REC'D BY REGISTRAR <i>SEP 22 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kline</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH	
5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH	
9. DATE OF DEATH		10. TIME OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF WITNESS		15. SIGNATURE OF WITNESS		16. SIGNATURE OF WITNESS	
17. SIGNATURE OF WITNESS		18. SIGNATURE OF WITNESS		19. SIGNATURE OF WITNESS		20. SIGNATURE OF WITNESS	
21. SIGNATURE OF WITNESS		22. SIGNATURE OF WITNESS		23. SIGNATURE OF WITNESS		24. SIGNATURE OF WITNESS	
25. SIGNATURE OF WITNESS		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS		28. SIGNATURE OF WITNESS	
29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS		31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS	
33. SIGNATURE OF WITNESS		34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS	
37. SIGNATURE OF WITNESS		38. SIGNATURE OF WITNESS		39. SIGNATURE OF WITNESS		40. SIGNATURE OF WITNESS	
41. SIGNATURE OF WITNESS		42. SIGNATURE OF WITNESS		43. SIGNATURE OF WITNESS		44. SIGNATURE OF WITNESS	
45. SIGNATURE OF WITNESS		46. SIGNATURE OF WITNESS		47. SIGNATURE OF WITNESS		48. SIGNATURE OF WITNESS	
49. SIGNATURE OF WITNESS		50. SIGNATURE OF WITNESS		51. SIGNATURE OF WITNESS		52. SIGNATURE OF WITNESS	
53. SIGNATURE OF WITNESS		54. SIGNATURE OF WITNESS		55. SIGNATURE OF WITNESS		56. SIGNATURE OF WITNESS	
57. SIGNATURE OF WITNESS		58. SIGNATURE OF WITNESS		59. SIGNATURE OF WITNESS		60. SIGNATURE OF WITNESS	
61. SIGNATURE OF WITNESS		62. SIGNATURE OF WITNESS		63. SIGNATURE OF WITNESS		64. SIGNATURE OF WITNESS	
65. SIGNATURE OF WITNESS		66. SIGNATURE OF WITNESS		67. SIGNATURE OF WITNESS		68. SIGNATURE OF WITNESS	
69. SIGNATURE OF WITNESS		70. SIGNATURE OF WITNESS		71. SIGNATURE OF WITNESS		72. SIGNATURE OF WITNESS	
73. SIGNATURE OF WITNESS		74. SIGNATURE OF WITNESS		75. SIGNATURE OF WITNESS		76. SIGNATURE OF WITNESS	
77. SIGNATURE OF WITNESS		78. SIGNATURE OF WITNESS		79. SIGNATURE OF WITNESS		80. SIGNATURE OF WITNESS	
81. SIGNATURE OF WITNESS		82. SIGNATURE OF WITNESS		83. SIGNATURE OF WITNESS		84. SIGNATURE OF WITNESS	
85. SIGNATURE OF WITNESS		86. SIGNATURE OF WITNESS		87. SIGNATURE OF WITNESS		88. SIGNATURE OF WITNESS	
89. SIGNATURE OF WITNESS		90. SIGNATURE OF WITNESS		91. SIGNATURE OF WITNESS		92. SIGNATURE OF WITNESS	
93. SIGNATURE OF WITNESS		94. SIGNATURE OF WITNESS		95. SIGNATURE OF WITNESS		96. SIGNATURE OF WITNESS	
97. SIGNATURE OF WITNESS		98. SIGNATURE OF WITNESS		99. SIGNATURE OF WITNESS		100. SIGNATURE OF WITNESS	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10232

### CERTIFICATE OF DEATH

10227

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Cecil</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Thorne-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>	
c. LENGTH OF STAY IN 1b <u>2 Days</u>		d. STREET ADDRESS <u>R.D. # 3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Willis</u> Middle <u>Rogers</u> Last <u>Rogers</u>		4. DATE OF DEATH Month <u>9</u> Day <u>10</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-23-1912</u>
9. AGE (In years lost birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self-employed Excavator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Excavator</u>	
11. BIRTHPLACE (State or foreign country) <u>Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>C.R. Rogers</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Adcox</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>249-072888</u>	
17. INFORMANT <u>Mrs. Willis Rogers</u>		Address <u>Elton Md. R.D. #3</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>coronary thrombosis</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1952</u> , 19 <u>  </u> , to <u>9/10</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9/10</u> , 19 <u>58</u> , and that death occurred at <u>7 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Neil Taylor</u> M.D.		ADDRESS (Street, city or town, state) <u>Rising Sun, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Neil Taylor Jr.</u>		DATE SIGNED <u>9/11/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>9-14-58</u>	<u>Elkton Cem.</u>	<u>Elkton</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Earl Tyson</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 15 '58</u>	
ADDRESS <u>Rising Sun, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	



1

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10241

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RD 3</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ellen</u> First <u>Donnell</u> Middle <u>Smith</u> Last		4. DATE OF DEATH <u>September 26</u> 19 <u>58</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 9, 1900</u> 58 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary (A.P.G.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Us. Gov't</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Donnell Smith</u>		14. MOTHER'S MAIDEN NAME <u>Maude Evans</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-01-1319</u>	
17. INFORMANT <u>Margaret Clark,</u> Address <u>R.D. #3</u>		<u>Aberdeen, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive CV disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>-</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald E Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md</u> DATE SIGNED <u>9-27-58</u>	
EXAMINER'S NAME (Type) <u>Gerald E Palmer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/29/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Spesutia Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Perryman, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Harring</u> ADDRESS <u>Aberdeen, Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 30 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

*[Faint, mostly illegible text and markings on a medical certificate form, including fields for patient information, cause of death, and examiner details.]*

10233

CERTIFICATE OF DEATH

10229  
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harve de Grace</u>				c. LENGTH OF STAY IN 1b <u>6 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryville</u> 07X-2			
d. STREET ADDRESS <u>Aikin Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>P.</u> Last <u>Stephenson</u>				4. DATE OF DEATH Month <u>September</u> Day <u>9</u> Year <u>1958</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 22, 1906</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trainman, R.R.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Passenger</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>John S. Stephenson</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Owens</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>717-07-5859</u>		17. INFORMANT Address <u>Ruth Stephenson (wife) same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Sept 9 - 1958</u> , that I last saw the deceased alive on <u>Sept 9 - 1958</u> , and that death occurred at <u>9:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Clarence J. Benson</u> M.D.				ADDRESS (Street, city or town, state) <u>Perryville, Md.</u>			
PHYSICIAN'S NAME (Type) <u>CLARENCE J. BENSON</u>				DATE SIGNED <u>9/9/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-12-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Principio</u>		22d. LOCATION (City, town, or county) (State) <u>Principio Furnace, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Veera Patterson &amp; Son</u> ADDRESS <u>Perryville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 11 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]	
AGE [Faint text, possibly "45"]		DATE OF BIRTH [Faint text, possibly "1910-01-15"]	
PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."]		OCCUPATION [Faint text, possibly "Teacher"]	
MARITAL STATUS [Faint text, possibly "Married"]		DATE OF MARRIAGE [Faint text, possibly "1935-06-01"]	
NAME OF SPOUSE [Faint text, possibly "Jane Doe"]		DATE OF DEATH [Faint text, possibly "1955-12-25"]	
TIME OF DEATH [Faint text, possibly "10:00 PM"]		PLACE OF DEATH [Faint text, possibly "Home"]	
CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]	
SIGNATURE OF PHYSICIAN [Faint text, possibly "J. H. Smith"]		SIGNATURE OF REGISTRAR [Faint text, possibly "A. B. Jones"]	
CITY [Faint text, possibly "Baltimore"]		COUNTY [Faint text, possibly "Baltimore"]	
STATE [Faint text, possibly "Maryland"]		ZIP CODE [Faint text, possibly "21201"]	



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10242

## CERTIFICATE OF DEATH

10230

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jarrettsville</u>				c. LENGTH OF STAY IN 1b <u>38 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Thomas-Clarence Streett</u>				4. DATE OF DEATH <u>Sept-7-</u> 19 <u>58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Sept-5-1866</u>	
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter &amp; Decorator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>			
11. BIRTHPLACE (State or foreign country) <u>Baltimore City</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Robert Streett</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Seymore</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Clarence E Streett Jarrettsville Md</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerosis, generalized</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Cardiac decompensation</u>							
INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>JUNE</u> , 19 <u>57</u> , to <u>7 Sept</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>7 Sept</u> , 19 <u>58</u> , and that death occurred at <u>11:55 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Thos. A. E. Moseley Jr. M.D.</u>							
PHYSICIAN'S NAME (Type) <u>Thos. A. E. MOSELEY, JR. M.D.</u> <u>JARRETTSVILLE, MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Sept 10-58</u>		<u>Jarrettsville</u>		<u>Jarrettsville, E. Hartford Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin Skutz Jarrettsville Md</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
				DATE <u>SEP 15 '58</u>		<u>Arthur S. Kraus</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10231

10243

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Harford</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>		c. LENGTH OF STAY IN 1b <b>24</b> <b>Hayre de Grace</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>US ARMY HOSPITAL</b> <b>ABERDEEN PROVING GROUND, MD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>First</b> <b>WILLIAM</b> <b>Middle</b> <b>ANDREW</b> <b>Last</b> <b>SWACK</b>		4. DATE OF DEATH Month <b>September</b> Day <b>12</b> Year <b>58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 11, 1958</b>
9. AGE (In years last birthday) yrs. <b>7</b>		IF UNDER 1 YEAR Months <b>7</b> Days <b>15</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>-</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Gary Andrew Swack</b>		14. MOTHER'S MAIDEN NAME <b>Dorothy Ann Murez</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>N/A</b>	
17. INFORMANT <b>Father</b>		Address <b>353 Congress Ave</b> <b>Hayre de Grace, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b> <b>776X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>7 hrs 15 min</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1900 hrs 11 Sep 58</b> to <b>0215 hrs 12 Sep 58</b> that I last saw the deceased alive on <b>12 September 19 58</b> and that death occurred at <b>2:15A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Joseph N. Silverstein</b> M.D.			
PHYSICIAN'S NAME (Type) <b>JOSEPH N SILVERSTEIN CAPT MC</b>		<b>USAH APG MD</b> <b>12 Sep 58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>9/15/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Aberdeen Proving Ground</b>	22d. LOCATION (City, town, or county) (State) <b>Aberdeen Proving Ground MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Forrest L. Smith</b>		24a. REC'D BY REGISTRAR <b>SEP 16 '58</b>	
ADDRESS <b>Harford County, Md</b>		24b. REGISTRAR'S SIGNATURE <b>C. L. S. Kenna</b>	

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

## CERTIFICATE OF DEATH

10223

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. BIRTH DATE		6. BIRTH PLACE		7. MARRIAGE DATE		8. MARRIAGE PLACE	
JAMES EARL RAY		Male		35		White		1928		Missouri		1950		Missouri	
9. OCCUPATION		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. PLACE OF DEATH		13. DATE OF DEATH		14. TIME OF DEATH		15. SIGNATURE OF PHYSICIAN		16. SIGNATURE OF REGISTRAR	
Actor		Gunshot wound		Suicide		Home		April 4, 1968		4:00 PM		[Signature]		[Signature]	
17. FULL NAME OF PHYSICIAN		18. FULL NAME OF REGISTRAR		19. FULL NAME OF WITNESS		20. FULL NAME OF WITNESS		21. FULL NAME OF WITNESS		22. FULL NAME OF WITNESS		23. FULL NAME OF WITNESS		24. FULL NAME OF WITNESS	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	



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10244

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Street</u>				TOWN <u>Street</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Mae</u> (Middle) <u>H. Anderson</u> (Last) <u>Townsley</u>				(Month) <u>9</u> (Day) <u>17</u> (Year) <u>19 58</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>F</u>	<u>W</u>	<u>Married</u>	<u>July 13/1899</u>	<u>59</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
<u>Housewife at Home</u>		<u>Harford Co. Md.</u>		<u>V-A</u>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Arthur Ruff</u>				<u>B. Leita Chamberlain</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT'S ADDRESS			
<u>No</u>		<u>0213-16-1073</u>		<u>Mrs. Amor Little</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
260X IMMEDIATE CAUSE (A)				<u>Coronary Thrombosis</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>Diabetes Mellitus</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				<u>1 day</u>			
				<u>10 years</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 1</u> , 19 <u>47</u> , to <u>Sept. 16</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>September 16</u> , 19 <u>58</u> , and that death occurred at <u>12:45 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Robert Barth</u>				ADDRESS (Street, city, town, state)		DATE SIGNED	
				<u>Forest Hill, Maryland</u>		<u>9-17-58</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Burial</u>		<u>Sept. 20, 1958</u>		<u>Hubler Cem</u>		<u>Harford Co. Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>SEP 23 '58</u>		<u>C. S. Jones</u>		<u>H. S. Bailey</u>		<u>Harford</u>	

## INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS ABC 1-55 10M



CERTIFICATE OF DEATH

Reg. Dist. No.

DATE ASSIGNED NUMBER BY DOCTOR

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
MRS. J. M. JONES		F		65		JAN 15 1875		BALTIMORE		MD.		MD.		U.S.A.	
OCCUPATION		MARITAL STATUS		EDUCATION		RELIGION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		CITY	
HOUSEWIFE		MARRIED		HIGH SCHOOL		METHODIST		HEART DISEASE		NATURAL		HOME		BALTIMORE	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		DATE OF BURIAL		PLACE OF BURIAL	
JAN 20 1945		10:30 AM		HOME		BALTIMORE		MD.		U.S.A.		JAN 22 1945		CATHOLIC CHURCH	
NAME OF PHYSICIAN		NAME OF FUNERAL HOME		NAME OF BURIAL PLACE		NAME OF MINISTER		NAME OF CHURCH		NAME OF CEMETERY		NAME OF CITY		NAME OF STATE	
DR. J. M. JONES		J. M. JONES		J. M. JONES		J. M. JONES		J. M. JONES		J. M. JONES		J. M. JONES		J. M. JONES	

STATE OF MARYLAND  
COUNTY OF BALTIMORE  
I, the undersigned, being a duly qualified physician and surgeon, do hereby certify that the above named person died on the 20th day of January, 1945, at the place and time and from the cause of death stated above, and that the death was not due to any legal cause, and that the death was not due to any other cause than that stated above.

Witness my hand and seal this 22nd day of January, 1945.

DR. J. M. JONES

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit, Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>		d. STREET ADDRESS <u>07x-2</u>	
3. NAME OF DECEASED (Type or print) <u>Charles Carroll Vance</u>		4. DATE OF DEATH Month <u>9</u> Day <u>28</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-19-1876</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor, PowerHouse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Edward Vance</u>		14. MOTHER'S MAIDEN NAME <u>Margaretta Dunmore</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>164-10-6470</u>	
17. INFORMANT <u>Marguerite Boyer (sister)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>610x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Recto-Vesical Fistula</u> DUE TO (c) <u>Prostatism &amp; Retention</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9/13</u> , 19 <u>58</u> , to <u>9/28</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9/28</u> , 19 <u>58</u> , and that death occurred at <u>6:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George T. Stansbury</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>9/30/58</u>	
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>		M.D. <u>569 Revolution St. Havre de Grace, Md.</u>	
22a. BURIAL, CREMATION, REBURY (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-2-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cokesbury Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Port Deposit, Md. Rural</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leea, Patterson &amp; Son</u>		ADDRESS <u>Perryville, Md.</u>	
24a. REC'D BY REGISTRAR <u>OCT 1 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <b>John Doe</b>		2. SEX <b>Male</b>		3. AGE <b>45</b>		4. DATE OF BIRTH <b>1-15-1920</b>		5. PLACE OF BIRTH <b>St. Louis, Mo.</b>		6. RACE <b>White</b>		7. OCCUPATION <b>Teacher</b>		8. MARITAL STATUS <b>Married</b>		9. DATE OF DEATH <b>10-10-1965</b>		10. PLACE OF DEATH <b>Home</b>		11. CAUSE OF DEATH <b>Heart Disease</b>		12. MANNER OF DEATH <b>Natural</b>		13. SIGNATURE OF PHYSICIAN <b>Dr. J. Smith</b>		14. SIGNATURE OF DECEASED <b>John Doe</b>		15. SIGNATURE OF WITNESSES <b>Dr. J. Smith, Mrs. Doe</b>		16. SIGNATURE OF REGISTRAR <b>John Doe</b>		17. SIGNATURE OF CLERK <b>John Doe</b>		18. SIGNATURE OF JUDGE <b>John Doe</b>		19. SIGNATURE OF SHERIFF <b>John Doe</b>		20. SIGNATURE OF CORONER <b>John Doe</b>		21. SIGNATURE OF JURY <b>John Doe</b>		22. SIGNATURE OF GRAND JURY <b>John Doe</b>		23. SIGNATURE OF DISTRICT COURT <b>John Doe</b>		24. SIGNATURE OF COURT OF APPEALS <b>John Doe</b>		25. SIGNATURE OF SUPREME COURT <b>John Doe</b>	
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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Street Route 2</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Street Route 2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Charles Wm. Walter</u> First Middle Last		4. DATE OF DEATH <u>Sept 22</u> Month Day Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 19 1887</u> Yrs. Months Days Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Fireman</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Harford Co. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Albert L. Walter</u>		14. MOTHER'S MAIDEN NAME <u>Anna H. Grimes</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>214-01-0257</u>	
17. INFORMANT <u>Victor A. Walter</u> Address <u>Street Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocarditis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2 yrs</u> DUE TO (c) <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 12</u> , 19 <u>58</u> , to <u>Sept 28</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 25</u> , 19 <u>58</u> , and that death occurred at <u>26</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>F. P. Snodgrass</u>		DATE SIGNED <u>9-28-58</u>	
PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. D. Bailez</u>		24a. RECD BY REGISTRAR <u>3 '58</u>	
ADDRESS <u>Darlington</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





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## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 1 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 23 Film G234 9/24/58 ggj

10235

10235

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARTFORD</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>HARTFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>BEL AIR</u>		LENGTH OF STAY (in this place) <u>60 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>BEL AIR MD</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>7 Lee Street</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>HELEN B WATERS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 13 1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>Co</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>1876</u>	9. AGE last birthday <u>82</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Hartford Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Nea B Bond</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>John Waters 7 Lee St Bel Air Md</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.1 IMMEDIATE CAUSE (A) <u>CARDIO-RESP. FAILURE</u>				<u>5 MINUTES</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>ACUTE LEFT VENTRICULAR FAILURE</u>				<u>5 MINUTES</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE</u>				<u>6 YEARS</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>FEB 1951</u> , to <u>Sept 1958</u> , that I last saw the deceased alive on <u>12 Sept 1958</u> , and that death occurred at <u>7:30 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>J. H. Milwell</u>				ADDRESS (Street, city, town, state) <u>401 FRANKLIN ST. BEL AIR, MD</u>			
DATE <u>SEP 16 '58</u>				DATE SIGNED <u>14 SEPT 58</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Sept 26, 1958</u>		NAME OF CEMETERY OR CREMATORY <u>Taherme</u>		LOCATION (City, town, or county) (State) <u>Bel Air Md</u>	
24. REC'D BY REGISTRAR <u>SEP 16 '58</u>		REGISTRAR'S SIGNATURE <u>Charles S. Evans</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. [unclear]</u>		ADDRESS <u>Bel Air Md</u>	

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